U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 25 July 2006

CASE NO.: 2005-BLA-5645

In the Matter of

KENNETH R. LOHR,
Claimant

v.

WRIGHT COAL COMPANY, INC.,
Employer

and

INSERVCO INSURANCE COMPANY/
PENNSYLVANIA SECURITY FUND,[1]
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Ron Carson, Lay Representative[2]
Lynda D. Glagola, Lay Representative[3]
For the Claimant

Gregory J. Fischer, Esquire
For the Employer

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[1] At the formal hearing, Employer's counsel stated that Rockwood Insurance Company had been liquidated. Furthermore, he stated that Inservco Insurance Company had "picked up" some of Rockwood's claims, and that it is the current carrier herein. Moreover, Pennsylvania Security Fund was identified as the third-party administrator (TR 8).

[2] Ron Carson is the Black Lung Program Director at Stone Mountain Health Services in St. Charles, Virginia (TR 4).

[3] Lynda D. Glagola is the Program Director at the Lungs at Work clinic in McMurray, Pennsylvania (TR 5).

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by Kenneth R. Lohr, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[4]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on December 6, 2005, in Pittsburgh, Pennsylvania. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Pursuant to leave granted at the formal hearing, Dr. Fino's deposition transcript, dated December 13, 2005, has been marked and received in evidence as Employer's Exhibit 3 (EX 3). (TR 33). As set forth in my Order Granting Extension of Time to File Closing Briefs, dated January 26, 2006, the deadline for submission of closing briefs was extended to February 10, 2006. Claimant's representative presented an oral closing argument at the end of the formal hearing (TR 34-35). Moreover, Employer counsel's letter brief, dated February 6, 2006, was timely filed.

The record consists of the hearing transcript, Director's Exhibits 1 through 36 (DX 1-36), Claimant's Exhibits 1 through 7 (CX 1-7), and Employer's Exhibits 1 through 3 (EX 1-3).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On May 26, 2004, Claimant, Kenneth R. Lohr, filed the current application for black lung benefits under the Act (DX 2).[5] On December 9, 2004, the District Director issued a Proposed Decision and Order awarding benefits (DX 27). Following Employer's timely request for a formal hearing (DX 29), this matter was referred to the Office of Administrative Law Judges for

[4] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on May 26, 2004 (DX 2), the new applications are applicable (DX 36).

[5] On the application form, Claimant indicated that he had previously filed a claim for Federal Black Lung benefits which had been denied (DX 2, Secs. 5-6). However, the record does not contain any other evidence to substantiate this assertion. Moreover, the presence or absence of a prior denied claim is inconsequential for the purpose of rendering this decision.

adjudication (DX 34-36). As previously stated, a formal hearing was held on December 6, 2005, and the record was held open for the submission of post-hearing evidence and closing arguments.

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner's disability is due to pneumoconiosis?

(DX 34; TR 6-9).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

The parties stipulated, and I find that Claimant engaged in coal mine employment for 17.42 years (DX 7; TR 7).

B. Date of Filing

Claimant filed the current claim for benefits under the Act on My 26, 2004 (DX 2). Employer stipulated, and I find, that the claim for benefits is timely filed (TR 6).

C. Responsible Operator

Employer, Wright Coal Company, Inc., stipulated, and I find, that it is the properly designated responsible operator in this case, under Subpart G of the Regulations (DX 5; TR 7-8, 16).

D. Personal, Employment, and Smoking History

Claimant, Kenneth R. Lohr, was born on December 26, 1935. He has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Esther Lohr (nee Bleigh) (DX 2, 9; TR 15). As stated above, Claimant has established 17.42 years of coal mine employment.

On direct examination, Claimant testified that he had performed various coal mine jobs, such as drilling coal, shooting coal, and cleaning coal by hand, in addition to performing his last usual coal mine job as a dozer operator (TR 16, 18-19). However, on cross-examination, Claimant stated that the whole time he worked as a dozer operator (TR 23). The latter statement is more consistent with the Employment History form, signed by Claimant on May 24, 2004, which indicates that he worked almost exclusively as a dozer operator, throughout his years of coal mine and non-coal mine employment (DX 5). Moreover, Claimant testified that he worked a total of 30 years as a dozer operator, of which about 17 years were spent in coal mine work,

and 13 years were spent in non-coal mine work for Season Limestone Company and Vogel Disposal. Furthermore, Claimant testified that his non-coal mine employment also entailed some dust exposure from moving limestone (TR 16, 23-24).

Claimant testified that his last usual coal mine job, as a dozer operator, was a dusty job. Claimant sat in a cab, which was not air-conditioned. In the summer months, the windows were open. Furthermore, the job entailed some heavy labor, particularly when he had to do repair work, such as changing the blades on the dozer. Furthermore, Clamant had to climb up and down the dozer at least four or five times daily, and carry five-gallon oil cans weighing 35 to 40 pounds each (TR 16-18). All of Claimant's coal mine employment was above ground (TR 23). Claimant left the coal mines in 1989, when he retired (DX 2). When asked why he stopped working that year, Claimant testified: "Breathing problems. I got sick at work. I'd had a heart attack the year before. I had open-heart surgery, went back to work for a year, and then I got sick, couldn't breathe. It was very hot, and having a hard time breathing." (TR 20).

On direct examination, Claimant initially testified that he was treated by Dr. Chuensumran, in 1989, for breathing problems (TR 20). After discussing various breathing medications prescribed by Dr. Chuensumran, Claimant testified that he has been seeing Dr. Chuensumran since 2001 (TR 20-21). On cross-examination, Claimant clarified this apparent inconsistency by explaining that there was a break in his treatment with Dr. Chuensumran (TR 26). In addition to his breathing medication, Claimant also takes heart medication. He occasionally experiences chest pain, and takes a nitro tab. However, Claimant is not currently seeing a heart specialist. Claimant has a family physician, Dr. Hyder, who prescribes the heart medication and treats him for his general medical condition (TR 26-28).

Claimant acknowledged a cigarette smoking history starting at age 15 (*i.e.,* 1950) and ending in 2001. However, Claimant stated that he quit smoking in 1987, for three years, and that on other occasions, he stopped smoking for five or six months at a time. Claimant stated that he "couldn't say for sure," whether he smoked for about 46 or 47 years. Furthermore, Claimant testified that, when he was smoking, he smoked "between a pack and two packs a day." On the other hand, Claimant also stated that, when he quit smoking in 2001, he only smoked "approximately a half pack a day." Moreover, Claimant stated that medical records, in 1988, indicating that he had been smoking two to three packs of cigarettes per day were not correct (TR 28-30).

Although Claimant has acknowledged a significant cigarette smoking history, as described above, I find that it still understates his actual smoking history. Notwithstanding his testimony to the contrary, I find that Claimant's treatment records in the late 1980's establish that Claimant actually smoked as much as three packs per day. In making this determination, I note that the Allegheny General Hospital History and Physical report, dated January 11, 1987, states, in pertinent part: "He does not smoke now, but he used to smoke 3 packs per day." (CX 7). Similarly, the Allegheny General Hospital Discharge Summary, dated January 26, 1988, states: "The patient used to smoke three packs per day." (CX 7). Moreover, the Allegheny General Hospital History and Physical report, dated January 25, 1988, states: "He stopped smoking cigarettes approximately 7 weeks ago but smoked 2-3 packs a day for 30 years prior to that." (CX 7). The above-referred records reflect the smoking history as reported on several occasions

at a time when Claimant was undergoing treatment for heart disease, including coronary artery bypass surgery. I find that Claimant's recollection regarding his early cigarette smoking history was fresher in the late 1980's than in December 2005, when he testified at the formal hearing. Moreover, Claimant had no incentive to exaggerate his actual smoking history to physicians who were treating him for his heart condition. Therefore, as of January 1988, I find that Claimant already had a 60 to 90-pack-year cigarette smoking history. Furthermore, even though Claimant may have quit smoking for a three-year period in the late 1980's and stopped smoking for additional shorter periods, Claimant acknowledges that he did not quit smoking entirely until 2001 (*i.e.,* 12 years after he stopped working as a coal miner). Accordingly, even if Claimant only smoked an additional ½ pack per day from 1991 to 2001, as suggested by his testimony, he would have a total cigarette smoking history of approximately 65 to 95-pack-years.

II. Medical Evidence

The medical evidence includes various chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, which are summarized below.

A. Chest X-rays

The case file contains various interpretations of chest x-rays, dated June 22, 2004 (DX 18/19, 20; CX 4; EX 1), February 14, 2005 (CX 6; EX 2), and March 15, 2005 (CX 1, 2), respectively.

Of the foregoing, the following are positive for pneumoconiosis under the classification requirements set forth in §718.102(b): Dr. Colella's interpretations (1/0, t/s, in 4 mid & lower lung zones) of the June 22, 2004 x-ray (DX 19) and (1/1, t/s, in 4 mid & lower lung zones) of the February 14, 2005 x-ray (CX 6); Dr. Gohel's interpretations (1/0, s/t, in 4 mid & lower lung zones) of the June 22, 2004[6] and March 15, 2005 x-rays (CX 2, 4); and, Dr. Cohen's interpretation (1/0, q/t, all six lung zones) of the March 15, 2005 x-ray (CX 1). Drs. Colella (CX 6), Gohel (CX 2, 4), and Cohen are all B-readers. Moreover, Drs. Colella and Gohel are dual-qualified B-readers and Board-certified radiologists.

On the other hand, the record also includes some negative interpretations under the classification requirements set forth in §718.102(b); namely, Dr. Duncan's finding of no parenchymal or pleural abnormalities consistent with pneumoconiosis on the chest x-ray, dated June 22, 2004 (EX 1); and, Dr. Fino's negative reading of the chest x-ray, dated February 14, 2005 (EX 2). Drs. Duncan and Fino are both B-readers (EX 1,2). Furthermore, Dr. Duncan is a dual-qualified B-reader and Board-certified radiologist.

In summary, the majority of the x-ray interpretations by B-readers and/or Board-certified radiologists are positive for simple pneumoconiosis under the classification requirements set forth in §718.102(b). As discussed below, Dr. Fino has questioned whether the type of small opacities and location of the opacities found by the "positive" readers are consistent with *coal*

[6] On the ILO classification form, Dr. Gohel mistakenly listed the date of x-ray as "06/23/04." However, the accompanying typewritten report includes an "Addendum A," which expressly states that it represents a "re-read of the radiograph dated 06-22-04." (CX 4).

worker's pneumoconiosis (EX 2, pp. 8-9). Furthermore, I note that Dr. Colella and Dr. Duncan, who reached opposite conclusions in their ILO classification analyses, both recommended a CT scan for further evaluation (DX 18; EX 1); and, that Dr. Fino testified at deposition that a CT scan is more sensitive than a regular chest x-ray in showing early changes from coal mine dust (EX 3, p. 20). Nevertheless, I find that Claimant has established the presence of minimal, simple pneumoconiosis based strictly on my consideration of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains numerous pulmonary function studies conducted during the period from June 22, 2004 to June 13, 2005 (DX 15; EX 2; CX 1, 3, 5a). All of the studies are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. In view of the foregoing, I find that the pulmonary function study evidence clearly establishes the presence of a total disabling pulmonary or respiratory impairment. Moreover, Employer has stipulated that Claimant suffers from a total pulmonary disability (TR 9).

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies which were administered on June 22, 2004 (DX 14) and February 14, 2005 (EX 2). On both occasions, the studies were only administered at rest. Neither of the studies are qualifying under the criteria stated in 20 C.F.R. Part 718, Appendix C. Therefore, the arterial blood gas study evidence does not establish total disability. However, as stated above, Employer has conceded that Claimant is totally disabled by a pulmonary impairment (TR 9).

D. Physicians' Opinions (including CT scan Interpretations)

The record contains descriptive interpretations of CT scans, dated July 28, 2003, August 21, 2003, and July 20, 2004 (CX 5a, 7). Various abnormalities were listed under the "Impression" section of the written reports, such as: prior CABG, other postoperative changes, previous granulomatous disease, parenchymal scarring at right lung base, parenchymal scarring with calcified granuloma at left lung base, and, a mass consistent in appearance with myelolipoma. However, none of the CT scan interpretations listed an "Impression" which specified a finding of pneumoconiosis. Furthermore, Dr. Gohel reported "no pleural effusion or suspicious pulmonary nodule"(CX 5a, 7). The CT scans, dated July 28, 2003 and July 20, 2004, was interpreted by Dr. Mark L. Bernstein and Dr. Leonard A. DeRiggi, respectively. Their professional qualifications are not in evidence. The August 21, 2003 CT scan was interpreted by

Dr. Shyam Gohel. As set forth above, Dr. Gohel is a B-reader and Board-certified radiologist. In view of the foregoing, I find that the CT scan evidence does not establish the existence of pneumoconiosis. Furthermore, it suggests that those physicians who interpreted the chest x-rays as negative for pneumoconiosis (*i.e.,* Drs. Duncan and Fino) are correct, even though they are in the minority. Nevertheless, even if the overall radiological evidence (*i.e.,* x-ray and CT scan combined) is insufficient to establish "clinical pneumoconiosis," such a finding would not preclude a finding of "legal pneumoconiosis."

The other relevant medical opinion evidence consists of the reports and/or deposition testimony of Drs. Celko (DX 13), Cohen (CX 1, 7), Hyder (CX 5), and Fino (EX 2, 3), who addressed the pneumoconiosis and disability causation issues.

Dr. David A. Celko, whose qualifications were reported by the District Director as "Board-certified in Internal Medicine, Subspecialty in Pulmonary Disease" (DX 27), examined Claimant on July 14, 2004 (DX 13). On a U.S. Department of Labor form, Dr. Celko referred to an attachment regarding Claimant's coal mine employment history (DX 13, Sec. B). The attachment consists of an Employment History form, dated May 24, 2004, as well as a typewritten statement entitled "Kenneth R. Lohr Employment History," which provided a detailed discussion of Claimant's coal mine and non-coal mine work history. On the form report, Dr. Celko also set forth Claimant's family, medical, and social history. The latter included a cigarette smoking history beginning at age 15 (*i.e.,* 1950) and ending "3 years ago" (*i.e.*, 2001). Claimant reportedly smoked "1 ½ - 2 (packs/day) x 15 yrs," and reduced his smoking until he quit (DX 13, Sec. C3). Dr. Celko also noted Claimant's complaints of sputum, wheezing, dyspnea, cough, chest pain, and ankle edema (DX 13, Sec. D1). Physical findings on examination of the thorax and lungs were essentially normal, except for a "healed sternotomy" on inspection, and "coarse rhonchi" on auscultation (DX 13, Sec. 4). In addition, Dr. Celko discussed various clinical test results obtained on June 22, 2004, as follows:

	Summary of Results
Chest X-ray:	Pneumoconiosis Lower 4 zones; 1/0 profusion Pulmonary nodule
Vent Study (PFS)	Severe Obstructive Vent Pattern, (decreased) DLCO, obstructive lung volumes
Arterial Blood Gas	Arterial hypoxemia
Other: ECG	Sinus Bradycardia (NSR)

(DX 13, Sec. D5).

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Celko stated: "(a) Coronary Artery Disease; (b) COPD/asthma; (c) pneumoconiosis; (d) pulmonary nodule (DX 13, Sec. D6). Dr. Celko did not specify the etiology of Claimant's coronary artery disease. However, he reported the etiologies of the final three diagnosed conditions, as follows: "6(b) occupational dust exposure(s) and/or cigarette smoking; 6(c) occupational dust exposure(s); 6(d) occupational dust, cigarettes, post inflammatory" (DX 13, Sec. D7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Celko stated: "totally disabled from pulmonary standpoint. Both

cigarette smoking and occupational dust exposures have contributed to his obstructive vent pattern. However, I believe that his occupational history is the major contributor based on x-ray findings. There is no current way to differentiate smoking vs. occupational exposure at this time." (DX 13, Sec. D8a). When asked the extent to which each of the diagnosed conditions contributes to Claimant's impairment, Dr. Celko simply stated: "disabled based upon COPD/asthma" (DX 13, Sec. D8b).

Dr. Robert A.C. Cohen, a B-reader who is Board-certified in Internal Medicine, Critical Care Medicine, and Pulmonary Disease, examined Claimant on March 15, 2005 (CX 1). In a report, dated April 15, 2005, Dr. Cohen set forth an 18-year coal mine employment history. He also discussed the history of Claimant's present illness, including shortness of breath and related problems. Under "Social History," Dr. Cohen reported a grossly understated smoking history of only 20 cigarette per day (*i.e.,* one pack) for "24 years" ending "4 years ago." However, Dr. Cohen also considered the smoking history, as reported by Dr. Celko. Accordingly, in other parts of the report, Dr. Cohen reported a "24-65 pack year" cigarette smoking history. In addition, Dr. Cohen set forth Claimant's occupational history, including non-coal mine work, and summarized some other medical evidence, such as Dr. Celko's opinion, positive x-ray readings, and a qualifying pulmonary function study.

In support of his finding that Claimant suffers from coal worker's pneumoconiosis, Dr. Cohen cited the following: an 18-year coal mine employment history, symptoms consistent with chronic lung disease, pulmonary function tests showing a severe obstructive lung disease with diffusion impairment and arterial blood gases indicative of mild hypoxemia, and, positive x-ray evidence for interstitial lung disease, pneumoconiosis. However, Dr. Cohen also noted that if the x-ray evidence were judged as negative, it would not change his opinion that Claimant has substantial historical and physiological evidence of coal worker's pneumoconiosis related to coal dust exposure. Moreover, Dr. Cohen stated that, even though Claimant "has a history of exposure to dirt and topsoil in his jobs as a dozer operator working covering garbage and the limestone strip mine," and that he "may have had some rock dust exposure in his work at the [Limestone] strip mine…[t]his would not be expected to result in significant obstructive lung disease." (CX 1, Dr Cohen report, p. 5). In addition, Dr. Cohen cited medical literature to support the conclusion that coal dust causes obstructive lung disease, such as the totally disabling pulmonary impairment evidenced by Claimant's pulmonary function results (CX 1, Dr. Cohen report, pp. 6-8). In summary, Dr. Cohen stated:

> **Conclusion:**
> It is my opinion that the sum of the medical evidence in conjunction with this patient's work history indicates that this patient's 18 years of coal mine dust exposure and his 24 to 65 pack years of exposure to tobacco smoke was (sic) significantly contributory to the development of his pulmonary dysfunction including moderate to severe obstructive lung disease and diffusion impairment. His resulting respiratory impairment is clearly disabling for his last coalmine job as a dozer operator.

(CX 1, Dr. Cohen report, p. 8).

In a supplemental report, dated November 18, 2005, Dr. Cohen reviewed additional evidence, such as CT scan evidence, an echocardiogram, pulmonary function results, and treatment records. In summary, Dr. Cohen stated:

> The additional medical records provided have not changed my opinion that Mr. Lohr has severe obstructive lung disease due to his exposure to coal mine dust and tobacco smoke. The additional chest imaging was not read specifically for pneumoconiosis and therefore does not add much useful information. He clearly has coronary artery disease, but this in no way causes obstructive impairments such as found in Mr. Lohr, and in fact, his left ventricular function was normal.
>
> **Conclusion:**
> It remains my opinion that the sum of the medical evidence in conjunction with this patient's work history indicates that this patient's 18 years of coal mine dust exposure and his 24 to 65 pack years of exposure to tobacco smoke was (sic) significantly contributory to the development of his pulmonary dysfunction including moderate to severe obstructive lung disease and diffusion impairment. His resulting respiratory impairment is clearly disabling for his last coalmine job as a dozer operator.

(CX 7, p. 3).

Dr. Syed Hyder has been Mr. Lohr's family physician since 1995, and has treated Claimant for his general medical condition, including breathing problems (CX 5, 5(a); TR 25-26). In a "To Whom It May Concern" letter, dated September 29, 2005, Dr. Hyder stated that Claimant "has a totally disabling pulmonary impairment;" and, that he made this diagnosis based upon Claimant's breathing symptoms of shortness of breath, productive cough and wheezing, as well as pulmonary function testing for many years. Dr. Hyder noted that Claimant's breathing medications include: oxygen 2L at night, Theophylline tablets, Spiriva Handihaler, Xyopenex nebulizer treatments, Aerobid inhaler, and Albuterol inhaler. Dr. Hyder also stated that Claimant's breathing impairment has caused severe limitations in his daily activities, and that he has been unable to work for many years. Regarding the etiology of Claimant's impairment, Dr. Hyder stated, in pertinent part:

> I believe that his breathing impairment has been contributed to by a combination of factors, his history of cigarette smoking as well as his many years of (sic) a dozer operator in the coal mines. I have also received Chest X-rays, B-readings indicating that Mr. Lohr has Coal Workers Pneumoconiosis.

(CX 5).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 1 – Deposition Exhibit 1), examined Claimant on February 14, 2005. In a report, dated March 14, 2005 (EX 2), Dr. Fino set forth Claimant's patient profile, occupational history, symptoms, past medical history, family history, review of systems, findings on physical examination, and the results of various clinical studies, including chest x-ray, spirometry, lung volumes, diffusing capacity, oxygen saturation, carboxyhemoglobin level, and arterial blood gas.

In addition, Dr. Fino reviewed other additional evidence, and set forth a flow sheet of chest x-rays, pulmonary function studies, arterial blood gases, and reported occupational and smoking histories. The latter did not include the cigarette smoking histories reported in 1987 and 1988, when Claimant was hospitalized for heart-related problems. In summary, Dr. Fino stated:

> **Diagnosis**
>
> I have reached the following diagnoses:
>
> 1. Severe obstructive pulmonary disease consistent with emphysema and chronic obstructive bronchitis.
> 2. Hypoxemia and mild hypercarbia secondary to above.
>
> **Discussion**
>
> The above information has been reviewed, and it is my opinion that this man does not suffer from coal workers' pneumoconiosis based on the following:
>
> 1. My reading of the chest x-ray is negative for pneumoconiosis. I would also note that the chest x-ray reading dated 7/14/04 [by Dr. Colella] is a reading that is not consistent with coal workers' pneumoconiosis. That is because there were no rounded opacities seen nor were the opacities seen in the upper lung zones.
>
>   The inhalation of coal mine dusts such as silica and coal may cause an abnormality to appear on the chest x-ray. The abnormalities are rounded opacities described according to the ILO standards as p, q, and r. These opacities involve a particular location of the lung; the first being in the upper portion of the right lung. Then, in descending order, the left upper zone, the two middle zones, and finally the two lower zones may be involved.
>
>   The ILO classification system characterizes all types of conditions that may be consistent with a pneumoconiosis. It is not specific to coal workers' pneumoconiosis. Some non-coal dust-related pneumoconioses may cause irregular opacities. However, the presence of only irregular opacities, in the absence of rounded opacities, is inconsistent with the diagnosis of coal workers' pneumoconiosis. In addition, opacities that are found in the lower zones only do not indicate a coal dust-related lung condition.
>
> 2. The significant obstructive abnormality is present due to cigarette smoking.
>
> 3. The significant reduction in diffusing capacity is consistent with pulmonary emphysema due to cigarette smoking.
>
> 4. The mild hypercarbia is quite consistent with cigarette smoking.

5. The TLC was not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis.

From a functional standpoint, this man's pulmonary system is abnormal. He does not retain the physiologic capacity, from a respiratory standpoint, to perform all of the requirements of his last job. There are two potential risk factors for this disability – coal mine dust exposure and smoking. In this instance, the clinical information is consistent with a smoking related disability. Even if chronic obstructive lung disease due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cm range. If we gave back to him that amount of FEV1, this man would still be disabled. This medical estimate of loss in the FEV1 was noted in working miners, that drop was not clinically significant. This man would be as disabled had he never stepped foot in the mines.

Conclusions

1. There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.

2. There is a disabling respiratory impairment present due to cigarette smoking.

3. From a respiratory standpoint, this man is disabled from returning to his last mining job or a job requiring similar effort.

4. Even if I were to assume that this man has legal coal workers' pneumoconiosis, it has not contributed to this disability. He would be as disabled had he never stepped foot in the mines.

(EX 2, pp. 8-10).

In his deposition testimony on December 13, 2005, Dr. Fino reiterated that, although Claimant is disabled by lung disease, the disability is due to cigarette smoking, not coal dust exposure. Furthermore, Dr. Fino found that the evidence does not suffer from clinical or legal pneumoconiosis. In reaching this conclusion, Dr. Fino cited the Claimant's overall clinical picture, including the x-ray readings, CT scan evidence, and pulmonary function results, as well as medical literature (EX 3, pp. 15-23). Moreover, Dr. Fino stated that the positive x-ray interpretations were undermined by the more sensitive CT scan evidence, which was negative for pneumoconiosis. Furthermore, Dr. Fino reiterated that most of the positive interpretations under the ILO standards were inconsistent with *coal worker's* pneumoconiosis. Finally, Dr. Fino specified that, even assuming the accuracy of Dr. Cohen's x-ray reading, he would still find that coal mine dust was not a contributing factor in Claimant's disabling obstruction (EX 3, pp. 23-27).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the record contains both positive and negative interpretations by well-credentialed B-readers and/or Board-certified radiologists. However, the majority of these interpretations are positive for simple pneumoconiosis under the classification requirements set forth in §718.102(b). Accordingly, based upon the x-ray evidence, I find that simple pneumoconiosis has been established under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As summarized above, the record contains CT scan evidence which does not establish the presence of pneumoconiosis. Dr. Cohen stated that the additional chest imaging "does not add much useful information," because it was not read specifically for pneumoconiosis (CX 7). On the other hand, Dr. Fino opined that the CT scan evidence does not describe changes consistent with the positive x-ray findings of pneumoconiosis (EX 3). As fact-finder, I find Dr. Fino's analysis of the CT scan evidence to be more persuasive. In making this determination, I note that the CT scan evidence does not simply fail to include a diagnosis of pneumoconiosis. The CT scan evidence reveals the presence of parenchymal scarring related to granulomatous disease. Furthermore, it shows no pleural effusion consistent with pneumoconiosis or any other disease (CX 5a, 7). However, the crux of this cases rests on the etiology of Claimant's total pulmonary disability, since this addresses the issues of "legal pneumoconiosis" and "disability causation."

As outlined above, Drs. Celko (DX 13), Cohen (CX 1, 7), Hyder (CX 5), and Fino (EX 2, 3) each provided opinions regarding these issues. As fact-finder, I must conduct a qualitative assessment of the conflicting medical opinion evidence by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning. As stated above, Drs. Celko, Cohen, and Fino are Board-certified pulmonary specialists. Accordingly, their relative qualifications are not a significant factor in rendering this decision. Dr. Hyder is a general family practitioner, who lacks the pulmonary credentials of Drs.

Celko, Cohen, and Fino. However, unlike the other physicians who had limited contact with Claimant, Dr. Hyder has been Claimant's treating physician for many years.

Dr. Celko related Claimant's total disability to "cigarette smoking and occupational dust *exposures*." (Emphasis added). Furthermore, he opined that Claimant's "occupational history is the major contributor based upon the x-ray findings." Dr. Cohen related Claimant's disabling pulmonary dysfunction to his 18 years of coal mine dust exposure and his 24 to 65 pack years of tobacco smoke exposure. Furthermore, Dr. Cohen stated that Claimant's non-coal mine work as a dozer operator, which included some rock dust exposure, "would not be expected to result in significant obstructive lung disease." Dr. Hyder found that Claimant's totally disabling pulmonary impairment is due to a combination of cigarette smoking and his work as a dozer operator in the coal mines. On the other hand, Dr. Fino found that Claimant's total pulmonary disability is due to cigarette smoking, and that if coal mine dust exposure contributed thereto, such a contribution would be negligible.

Having carefully considered the above-referred medical opinions, I accord the most weight to Dr. Fino's opinion. In making this determination, I note that Dr. Celko's opinion failed to distinguish between the effects of Claimant's coal mine and non-coal mine occupational exposures. In addition, Dr. Celko failed to explain how the x-ray findings of minimal, simple pneumoconiosis support his conclusion that Claimant's "occupational history" is "the major contributor" to such disability. Furthermore, I find that Dr. Celko understated Claimant's actual cigarette smoking history. Moreover, Dr. Celko's opinion was based entirely on the findings obtained on the July 14, 2004 examination (DX 13). Therefore, I accord his opinion less weight.

Notwithstanding Dr. Hyder's status as Claimant's treating family physician, I find his opinion regarding the etiology of Claimant's pulmonary disability to be cursory and poorly documented (CX 5). Therefore, I also accord Dr. Hyder's opinion little weight. On its face, Dr. Cohen's opinion is reasoned and documented. Furthermore, Dr. Cohen, like Dr. Fino, considered other medical data and cited medical literature. As stated above, Dr. Cohen ruled out any significant contribution by Claimant's non-coal mine occupational exposure, while relating the total disability to 18 years of coal mine dust exposure and a 24 to 65 pack year cigarette smoking history. However, Dr. Cohen also understated Claimant's actual cigarette smoking history. Moreover, unlike Dr. Fino, Dr. Cohen accorded little weight to the CT scan evidence, which was negative for (clinical) pneumoconiosis. Although Dr. Fino also understated Claimant's cigarette smoking history, I find that Dr. Fino's opinion regarding the etiology of Claimant's total disability is more consistent with his actual cigarette smoking history of approximately 65 to 95-pack-years ending in 2001, which dwarfs Claimant's coal mine employment history of 17.42 years as an above ground dozer operator ending in 1989. Furthermore, I find it somewhat inconsistent for Dr. Cohen to minimize the possible effect of Claimant's dust exposure as a dozer operator in non-coal mine jobs for about 13 years, while finding that dust exposure as a dozer operator in 17.42 years of coal mine employment is significant. In view of the foregoing, I find Dr. Fino's opinion is better reasoned and better documented, and I accord it the most weight. Therefore, I find that Claimant has failed to establish pneumoconiosis under §718.202(a)(4).

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from (clinical or legal) pneumoconiosis. In summary, I find that although the preponderance of the x-ray evidence is positive for minimal, simple pneumoconiosis, the more credible medical opinion evidence is negative for pneumoconiosis. As stated by Dr. Fino, whose opinion I find most persuasive, a CT scan is more sensitive than a chest x-ray in finding radiological evidence of pneumoconiosis. Since the CT scan evidence is negative for pneumoconiosis, it undermines the positive x-ray finding of pneumoconiosis. Furthermore, for the reasons outlined above, I credit Dr. Fino's opinion that Claimant's coal mine dust exposure played a negligible role, if any, in his total pulmonary disability. Therefore, taken as whole, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997); *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000).

Causal Relationship

Since Claimant has failed to establish the presence of (clinical or legal) pneumoconiosis, he also cannot establish that the disease arose from his coal mine employment. If Claimant had established the existence of pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203. However, in order to be eligible for benefits, Claimant still must establish that he suffers from a totally disabling pulmonary or respiratory impairment, and that such total disability is due to pneumoconiosis.

Total Disability

Employer has stipulated, and I find, that Claimant suffers from a total pulmonary disability, as provided in 20 C.F.R. §718.204(b). (TR 9).

Total Disability Due to Pneumoconiosis

Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease unrelated to coal mine employment.

20 C.F.R. §718.204(c).

For the reasons outlined above, I accord the most weight to Dr. Fino's opinion. Therefore, I find that Claimant did not establish total disability due to pneumoconiosis under §718.204(c).

Conclusion

Notwithstanding the preponderance of the positive x-ray evidence for pneumoconiosis, when weighed together with other medical evidence, the record as a whole fails to establish (clinical or legal) pneumoconiosis. Furthermore, although the record establishes that Claimant suffers from a totally disabling pulmonary or respiratory impairment, the evidence does not establish that pneumoconiosis is a substantially contributing cause of Claimant's total disability. In view of the foregoing, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of Kenneth R. Lohr for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S.

Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).